

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

57-021846  
STATE FILE NUMBER

**FILED JUN 28 1957**  
40883-57

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 226

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Marion</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Indiana</u> b. COUNTY _____					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Hammond</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Levering Hospital</u>				Length of stay in lb _____		d. STREET (If outside, give location) ADDRESS <u>6605 Jefferson</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Hause</u> Middle _____ Last _____						<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 13, 1957</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XX</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>XX</u>		11. BIRTHPLACE (City and state or country) <u>Hannibal Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Hause</u>				14. MOTHER'S MAIDEN NAME <u>Muriel Oglesby</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>XX</u> <u>XX</u>				16. SOCIAL SECURITY NO. <u>XX</u>		17. INFORMANT Address <u>William Hause Hammond Indiana</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary atelectasis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Premature birth</u> DUE TO (c) <u>Premature rupture of membranes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congenital heart disease (interauricular septal defect - patent foramen ovale)</u>								INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u>  <u>6 weeks</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>7615</u>						
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION		COUNTY _____ STATE _____				
21. I attended the deceased from <u>June 13, 1957</u> to <u>June 14, 1957</u> and last saw her <u>alive</u> on <u>6-14-57</u> Death occurred at <u>8:40 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Thomas R. Burns M.D.</u>				22b. ADDRESS <u>Hannibal, Missouri</u>		22c. DATE SIGNED <u>6-17-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE <u>6-15-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hannibal Mo</u>			
24. FUNERAL DIRECTOR ADDRESS <u>W. Crawford Smith Hannibal Mo</u>				25. DATE RECD. BY LOCAL REG. <u>6-21-1957</u>		26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Luck, Jr. &amp; C. J. Fisher</u>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE **BR 44 # 413**  
diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

RECEIVED JUN 25 1957  
MARION CO. HEALTH DEPT.  
DATE FILED JUN 25 1957

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
by me, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 4

P. O. Address 2/annul

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.